Case Consultation: Unremitting Depression

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Case Consultation is a new regular feature in the *Journal of EMDR Practice and Research*. In this article, an eye movement desensitization and reprocessing (EMDR) clinician briefly describes a challenging case in which a man, "George," was referred for EMDR for treatment of a depression that began more than 2 years previously. After all his reported traumatic memories were completely processed with EMDR, George remains severely depressed and the therapist asks how to proceed effectively with treatment. Responses are written by three experts. The first expert, Robin Shapiro, describes a comprehensive list of possible etiologies, including attachment, early trauma, genetic, and other biological causes and their appropriate EMDR, ego state, or medical treatments. The second expert, Arne Hofmann, reviews the treatment that was provided and makes suggestions for alternate treatment targets, suggesting that the therapist could address the client's belief that "nothing will change" and try the EMDR inverted protocol. The third expert, Earl Grey, recommends that the clinician focus on addressing small "t" traumas, even if the client indicates that he or she has little to no disturbance and explains how to develop and implement a "restorative life span target sequence."

Keywords: EMDR; depression; consultation; treatment

Therapist's Request

"George" was referred to me for eye movement desensitization and reprocessing (EMDR) for treatment of a severe depression that began more than 2 years previously. I have provided about 10 sessions of EMDR (F. Shapiro, 2001) to George. Targets included the disturbing events that occurred during his involuntary hospitalization for a mood disorder and the other disturbing life events that preceded his hospitalization. He no longer reports any distress related to the hospitalization or prior events, no longer has any intrusive memories about them, and no longer ruminates about them. His original negative cognition (NC) was "I'm a bad person," and this has shifted to "I'm okay" with high validity. He no longer has any traumatic symptoms because these all seem to have been completely resolved with EMDR.

However, this resolution gives George absolutely no satisfaction because he remains severely depressed. He has been unable to return to work, remaining on disability. He reports no pleasure in any daily activity and expresses hopelessness with no expectation of future improvement. He has a hard time mobilizing himself to do anything, although he goes for daily walks with his supportive wife. He is taking medications: antidepressants, antipsychotics, and mood stabilizers.

After completing our work on his traumatic memories, we refocused our attention on his depression, making this a target, with the new NC, "I'm a failure." We did floatbacks on his affect and his current NC (I'm a failure), but no memories were elicited, and he insists that his life was fine before the events predating his hospitalization—which we have already processed and which are no longer upsetting. George reports an ordinary uneventful childhood with no distressing incidents and no prior experiences in which he felt like a failure. He insists that there are no life events that now cause him any emotional disturbance, and that

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he no longer ruminates about the past; now, he simply ruminates about how depressed he is and his belief that nothing will change.

We have done EMDR on his current depressive experience, with a couple of targets—the image of his feeling hopeless and his associated losses—but it actually seems to get more depressing because his associations tend to be very negative. We cannot do any resourcing because George cannot imagine anything positive. Nothing seems to shift with processing, and he remains mired in this deep depression.

It seems like our failure with EMDR mirrors his sense of personal failure, and so I hesitate to continue. Is there anything we can do?

Response From Expert No. 1, Robin Shapiro

According to van der Kolk et al. (2007), EMDR is an effective and expeditious treatment for posttraumatic stress disorder (PTSD) and resulting depressive symptoms. In adult-onset trauma, it works quickly. Child-onset traumas often take longer to clear. However, depression may have other causes, and its appropriate treatment depends on its etiology.

Depression is increasingly being conceptualized as a bodily inflammatory process. Physical illness or trauma and emotional trauma or grief can start the process, say Hedaya (2009); Krishnadas and Cavanagh (2012); Raison et al. (2012); Wager-Smith and Markou (2011); Weil (2011); Zunsain, Hepgul, and Pariante (2012); and many others. They find that people hardwired for anxiety are more likely to get stressed and then depressed. Remember the last time you had the common inflammatory process of a high fever? Your body went into a dorsal vagal (shutdown) mode to get you to lie down and heal. If you didn't have the excuse of the fever and you were exhausted, had no appetite, had no pleasure, and couldn't connect well with others, we might diagnose you with depression. According to the proponents of the inflammation–depression connection, a body of a person with depression is going into a similar state in an attempt at self-healing.

So what to do with George? Given that he was committed for a mood disorder, you want to know his genetic, attachment, and complete trauma history. You need to find out about changes or stressors in his current life. To get that information, you might do a genogram to find out if anyone else in the family has a history of depression, anxiety, or other mood disorders; what George has personally experienced with his mood disorder; if there were any attachment disruptions early on; if there were periods of chronic stress or trauma in George's life; or if there were any big, unresolved losses in George's life. If you find the attachment, loss, stress, or trauma issues, EMDR procedures may be sufficient to tackle the problem. If it's an attachment issue, you need to assume a longer therapy possibly targeting mom and baby, then mom and toddler, and then mom and older kid scenes using straight EMDR ala Kitchur's (2005) strategic developmental model: "Imagine you're a baby in your mother's arms. Look up at her face. What emotion do you notice now? What sensation?" And use the standard protocol to clear whatever is there. You might resource using Steele's (2007) "constructing a secure self" work: "Imagine you as an adult, holding that baby you." Or Knipe's (2009) work: "Have your adult look at that child you with loving eyes." You tackle the issues and watch the person slowly come out of the fog.

If it's a chronic trauma or trauma from long ago, it will still be a longer-than-10-session therapy. Start at the early-in-life traumas and work up to now. The more you clear, the more the depression should lift.

If it's chronic stress, use all three prongs to clear the past and present stressors, then use future templates to program new responses to the stressors.

If it's bipolar disease, you will educate your client about the disease, find the best psychiatrist or psychiatric nurse practitioner in town, and work with your client to take medications, take supplements (omega-3s, aspirin, and other anti-inflammatories can be helpful), have a regular schedule, and learn to manage this chronic disease. EMDR's third prong, the future template, can be useful for internally practicing good self-care. EMDR's first and second prongs can help to clear the distress over the diagnosis. Anxious people are more likely to get stressed and depressed.

If you see no evidence of current or former trauma or attachment issues or of bipolar disorder, it's time to focus on other physical etiologies. Had George been taking stimulant drugs such as cocaine or amphetamines? Remember, what goes up can crash down, stunning people into low (dorsal vagal) states. Ecstasy and amphetamines deplete serotonin in the brain, creating an inability to feel good. These are the obvious causes. For more obscure physical causes, you need to send your client to a good medical person to look for the underlying cause of this so-far-intractable depression. Many psychiatrists miss these physical issues, so a referral to a good internist can work miracles. Here's what the doctor should look for:

- Hormonal issues: hypothyroid, low testosterone, or other insufficient hormones
- Underlying low-grade infections

- Nutritional imbalances, especially vitamin D deficiency
- Extremely low blood pressure
- Chronic injury or pain that may create either a body-wide inflammatory response creating depression or an endogenous opiate reaction that mimics/creates depression
- Any signs of tumors in the brain, glands, or any place that could cause a depressive response
- Any systemic inflammatory diseases not listed previously

If George is depressed for one of these reasons, you may still use EMDR to clear the distress over being ill and to support him to do whatever he needs to do to heal and raise his mood. Focus on his distress at the diagnosis (if any) or install his relief that there is a known, fixable cause. Use future templates to support doing what he needs to do.

No matter what the cause of his depression, don't give up on George. Social engagement lifts mood. Abandonment tells him that he is right to be hopeless. Let him know that you're in his corner. Let him know that you know how distressing it is to be so depressed. Stand with him while you figure out what happened and what to do about it.

Response From Expert No. 2, Arne Hofmann

The treatment of an unremitting depression is a serious challenge, and EMDR is not a magic bullet for every case. However, EMDR can be a very valuable tool in the treatment of those patients who otherwise often stay unremitted or who are being treated with electroconvulsive therapy.

George seems to suffer from a severe major depression that is not remitting under a complex medication and a well-planned psychotherapy. If I had a consultation with the therapist, I would try to develop with the therapist the next possible treatment steps along the following areas:

1. Because all the current treatment has not brought significant relief for George, I would have a second look at *somatic contributors*. There are several medications and substances that can cause or support a depression and that should be terminated or substituted. Antihypertensive medications (especially beta-blocking agents) not only reduce the blood pressure but also sometimes have a depressogenic effect of their own. Also, alcohol and benzodiazepines, especially in an overt or latent addiction situation, are among the most common culprits for enhancing or even triggering a depressive episode. As a third possible somatic contributor, the chameleon of internal medicine, a thyroid problem, especially hypothyroidism, should be excluded. Thyroid problems can mimic several internal, psychosomatic, and psychiatric disorders—depression is one of them. This is especially the case if the mood stabilizer that George takes is lithium. Lithium is known to affect the thyroid function and controls of the thyroid-stimulating hormone (TSH); a check for malfunction of the thyroid feedback loop is usually recommended.
2. While *working with the past events* in his depression, the involuntary ("traumatic") hospital stay is only one of the events that George needs working on. His depression (and suicidality?) has started earlier, and usually, there are events closely linked with the beginning of a depressive episode. Many of these *episode-triggering events* are related to losses and humiliations and would often qualify as "attachment trauma." Also, if George suffered from prior depressive episodes, the episode-triggering events of these prior episodes and potential traumatic events linked with these episodes should be processed too (even if the score in the subjective units of disturbance [SUD] scale is only 3 or 4 and the memory is not intrusive any more). I assume this has been done by the therapist and add this only for reasons of completeness.
3. One of the most successful ways to work with some clients with depression is the work with *belief systems*. The therapist has tried this, but the floatback/affect bridge as well as the question of events that are linked with experiences of "I am a failure" ("proof memories" according to de Jongh) did not elicit any new stressful events. However, if the current depressive state can be altered (e.g., resource activation techniques) I would try a second look at the belief systems later. Sometimes the current state of a patient with depression does not allow to do more memory work. In a later part of the therapy process, however, the same belief systems and memories can be far easier accessed and worked with.
4. There are some cases of depression (most of them chronic cases) where, similar to some cases of complex PTSD, the work with past memories is not helpful to bring the patient out of his highly symptomatic present "state." In some of these cases, either the past is so complex (and full of amnesias) that it cannot be processed first, or the present is still so stressful that every time you focus on the past, the negative present intrudes in the therapy process. For these cases, we have developed an *inverted EMDR protocol* (Hofmann, 2009).

Instead of focussing on the past first then on the present and then on future (as we do in the EMDR standard protocol), we focus on the potential problems of the next days (future) and the present first before later working with the past. To do this successfully, the activation of resource networks is necessary. Imaginary resources (such as the safe place) are only one of several possibilities of resource development that I can only touch here (Korn & Leeds [2002] could explain this much better.). In my view, a resource is an activated (memory) network linked with *a positive feeling the patient can feel in his or her body*. Imagination is not necessary for this type of resource work. The little changes in body feelings can be elicited during a therapy session and can make a lot of difference for a patient. However, this kind of resource work may need more time than the 10 sessions George had already. Some patients need many months to come out of a completely resource-depleted state. Most of the resources that they develop are around attachment persons (including possibly the therapist), attachment animals, little successes during therapy, and so forth. Perhaps in one of these areas, the therapist and I could find something that could help find a next possible step for the treatment of George.

Response From Expert No. 3, Earl Grey

Based on the information provided, the following steps can add in increasing a positive treatment outcome. I recommend that the therapist clearly conceptualize the presenting issues using the tenets from F. Shapiro's (2001) adaptive information processing (AIP) model, followed by developing and reprocessing the client's life span events using a restorative life span target sequencing plan (Grey & Morrow, 2011).

Adaptive Information Processing Case Conceptualization

George sought EMDR treatment because of a traumatic reaction to an involuntary hospitalization. He defines the hospitalization as a large "T" trauma. This disturbing event exacerbated his depression that seems to have been persistent during his adulthood. George reports no other large T traumas throughout his life. Because of the nature of human beings, humans have experiences with subclinical stress and disturbance (Stewart-Grey, 2008). It is the subclinical or "small t trauma" disturbance that are likely fueling in part George's depressive symptoms. Because the feeding events are likely nontraumatic, George is not identifying these events as contributing factors. The longevity of George's depressive symptoms is also supported by his NCs being in the theme of value, described by F. Shapiro (2001) as responsibility defectiveness (Grey, 2011; Stewart-Grey, 2008). Furthermore, there seems to be genetic chemical factors as evident by the need for psychotropic medication. Addressing the chemical intervention is outside of the scope of this response.

Finally, George is indicating that his past is uneventful, his present is full of failure, and the future is hopeless. With the pervasiveness of these small t trauma, the potential genetic influences, and the challenges with no recollection of "Ts" across the three prongs, George would not be a candidate of traditional EMDR protocols. To effectively treat George, it is recommended that the clinician include a restorative protocol synthesized within the traditional eight phases of EMDR treatment. There is evidence that George has a desire for wellness, as evident through his attachment to his "supportive" wife and his participation in bilateral stimulation (daily walks). Bilateral stimulation activates the frontal lobe in general (Hammond, 2008; Squire et al., 2008). George's willingness to participate in his relationship and walks provide the foundation to support the appropriateness of a restorative EMDR treatment approach.

Developmental Sequencing Plan

Discussing developmental life stages with George will help to identify small t traumas that are seemingly inaccessible. The purpose of this process is to identify developmental tasks that likely required external assistance from a caretaker because these are points in a person's life when he or she may not have been able to develop an internal locus of control and a meaningful attachment to self. The common result of small t traumas from developmental tasks is a maladaptive internal locus of self with an extreme external locus of control mirrored by depression and destructive negative beliefs about self (Davies, 2004; Lewis & Elman, 2008).

In EMDR, a commonly used cognitive interweave addresses this issue by having the client process an imagined interaction between the child self and the adult self. F. Shapiro (2001) states that a cognitive interweave using a child and adult self can help the client "recognize that they are no longer a vulnerable child" (p. 257).

This procedure is a core element in the developmental target sequencing plan in which each target is

processed with a focus on restoring the relationship between two perspectives of self. The most common dichotomous perspective is a big self and a little self. When we are dealing with a person who is a parent, the parent self versus the individual self can also be effective. The goal is having two elements of self: one that possesses the skills necessary to support, nurture, and protect and the other element of self being open to accepting the support, nurturing, and protection. The process is founded in the personality development of a child and is a key feature in the development of our perceptions as adults (Davies, 2004; Grey, 2010; Grey & Morrow, 2011; Nico & Daprati, 2009).

When choosing the target events, the client and clinician will only select experiences that would foster great internal locus of control using both concepts of self (i.e., big and little). Common developmental events that lead to a child's dependence on an external locus of control are (a) "beam of light," the first gaze between mother and child directly following birth; (b) learning to stand independently; (c) learning to speak; (d) learning to walk; (e) having one element of self protect the other, increasing internal safety and security; (f) successful play activities; and (g) specific life events that the client identify as pivotal in his or her life. These are only suggestions based on typical human development. The client may identify these life events as neutral or positive. Developmental life events must be negotiated between the therapist and the client. The list provided is a suggested list of human developmental life tasks. Once we have identified the developmental target sequencing events, we will use the traditional EMDR protocol. The clinician will want to check on every target using standard EMDR procedures for the target setup (F. Shapiro, 2001). If an NC and disturbance exists, then the clinician will want to be prepared to use the previously suggested interweave within the full past reprocessing protocol.

In George's case, we could also use EMDR to process his daily walks with his wife as a resource. Using his daily walks and adding an additional part of self (little George or Big George) to help build the relational attachment for George's internal self might be a helpful place to begin. The previously established supportive relationship in addition to the primitive nature of walking and development of walking can help support growth toward restorative resolution. The developmental sequencing plan is intended to increase an adaptive attachment to one's internal self. This process is indicated when a client presents with apparent deficiencies in the internal locus of control and with no identified traumatic or distressing target events.

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